Congress of the United States
Washington, DC 20515

January 9, 2015

Mr. Marc Goldwein
Senior Policy Director
The Committee for a Responsible Federal Budget
1899 L Street, N.W., Suite 225
Washington, D.C. 20036

Dear Mr. Goldwein:

Thank you for appearing before the Subcommittee on Health on Tuesday, December 9, 2014, to testify at the hearing entitled "Setting Fiscal Priorities."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions with a transmittal letter by the close of business Monday, January 26, 2015. Your responses should be mailed to Adrianna Simonelli Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to **Adrianna.Simonelli@mail.house.gov**.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Joseph R. Pitts

Joseph R. Pitts
Chairman
Subcommittee on Health

cc: Frank Pallone, Jr., Ranking Member, Subcommittee on Health

Attachment

Attachment —Additional Questions for the Record

The Honorable Joseph R. Pitts

1. In addition to the newly created and expanded entitlement programs in the Affordable Care Act, the law included a number of mandatory programs not subject to annual review by Congress. One program, the Prevention and Public Health Fund, was given a permanent mandatory appropriation – putting the program on permanent auto pilot. While I'm a strong proponent of prevention strategies and programs in health care, I think Congress should do its job and annually scrutinize whether taxpayer dollars are being spent wisely. As a general matter, do you think it makes sense for Congress to put more federal programs on the mandatory side of the ledger or should Congress take a more active role in annually reviewing the cost and benefits of federal programs?

2. Under Medicare Parts B and D, upper income beneficiaries pay higher premiums based on their higher levels of income. [Part B has been income-adjusted for many years, and Part D was further income adjusted in the Affordable Care Act/"Obamacare."] The president's FY2015 budget endorses a policy of further increasing a income-adjusted Medicare premiums until capping the highest tier at 90 percent. As the president said in that budget, "this proposal would help improve the financial stability of the Medicare program by reducing the federal subsidy of Medicare costs for those who need the subsidy the least." Charging wealthier seniors more is a policy that has often enjoyed bipartisan support, so do you believe this would be a useful offset for a large SGR package?

3. GAO and the HHS Inspector General have reported for years on various financing arrangements that allow states to obtain billions of dollars in additional federal Medicaid matching funds without a commensurate increase in state funds to finance the nonfederal share of Medicaid. Once such arrangement involves taxing health care providers. In his budget, the President has called for phasing down the Medicaid provider tax threshold from the current level of 6 percent to 3.5 percent. The president's Fiscal Commission recommended eliminating the use of provider taxes for providing the nonfederal share of Medicaid funding. What do you think about this policy recommendation and about state pushback on the policy?

4. Under the Medicaid disproportionate share hospital (DSH) program, states make payments to hospitals treating large numbers of low-income patients in order to recognize the disadvantaged financial situation of such hospitals because low-income patients are more likely to be uninsured. Industry reports have indicated that hospitals are yielding tremendous financial gains from Medicaid expansion. Thus, now that the Affordable Care Act has been implemented, are DSH payments even necessary in states that expanded Medicaid?

5. There have been five bipartisan plans to help save Medicare introduced in this president's term: (1) Rivlin-Domenici, (2) Rivlin-Ryan, (3) The Fiscal Commission, (4) Simpson Bowles's own plan, and (5) a plan by former Senator Joe Lieberman and Senator Tom Coburn. The Lieberman-Coburn plan has been proposed in legislative text and was scored by the Actuary of the Medicare program. The Actuary said that, if this legislation was adopted, it would prevent Medicare's insolvency for decades, and *reduce* seniors' premiums so they would be *lower than under current law*. Can you talk about what you think are the most viable pieces of these five proposals for Congress to adopt?

6. According to information released by the Actuary of the Centers for Medicare and Medicaid Services, drug spending is projected to hold steady for the foreseeable future at about 10 to 15 percent of National Health Expenditures. However, the Actuary did note that the emergence of specialty drugs presents cost challenges for some payers. This is especially the case in Medicaid, where individuals

receiving life-saving cures may churn in and out of the program based on their income. Unlike the defacto price control in the Medicaid program, the Medicare program has the benefit of a competitive program with varying formularies and plans, where a senior can pick a plan that meets his or her needs. So, have any of you thought about targeted policies to give plans and states more control over their drug spending?

7. CBO has estimated that repealing or delaying the IRS' authority to fine Americans for failing to buy government-approved coverage, otherwise known as the individual mandate, would result in tens of billions of dollars in savings for federal taxpayers. Taking away IRS' authority to punish Americans under Obamacare seems like a common sense proposal to limit government and save taxpayer dollars. One objection to this idea we often hear is that an individual mandate is necessary to cover pre-existing conditions. However, isn't it true that we can cover pre-existing conditions without an individual mandate while ensuring market stability through other mechanisms? (e.g. Medicare late enrollment penalties, high-risk pools, continuous coverage underwriting protections, etc.)

8. The Affordable Care Act included $1 trillion in tax hikes and more than $700 billion in reductions in Medicare, spent on government programs not for seniors. The House recently passed a bill using tax increases and Medicare cuts to offset increases in Medicare *and Medicaid* spending. Can you talk about challenges with or any concerns with using tax hikes to pay for increased Medicare or Medicaid spending—rather than using targeted, common-sense Medicare and Medicaid reform policies?

9. The Affordable Care Act/"Obamacare" took more than $700 billion to spend on new government programs not for seniors. One of the big pay-fors for the bill was across-the-board annual reductions in the growth rates of Medicare payments for hospitals. Under the law, these cuts are scheduled to continue to be reduced each year, permanently. As a result, the Actuary of the Medicare program has said that if these cuts continue as outlined in the law, either (a) up to 15 percent of hospitals could close and many hospitals would stop taking Medicare patients, or (b) Congress reverses the cuts, increasing the rate of Medicare spending and accelerating the insolvency of the program. In your view, would it be better to scrap these reductions and replace them with other policies – and if so, why?

10. MACPAC has recommended creating a statutory option for states to implement 12-months continuous eligibility for children in CHIP. To what extent does a 12-month continuous eligibility option result in CHIP coverage for individuals from families with incomes above the CHIP eligibility thresholds? How does a 12-month continuous eligibility policy affect the required premiums and cost sharing for an enrollee? Could it result in an enrollee paying more or less than required based on their current income?

11. Under the ACA households at 400% of federal poverty level (with income of nearly 100k) have and will receive subsidies to purchase coverage on the exchange. In your testimony, you note that reducing this subsidy level to 300% of federal poverty would result in savings of nearly $181 billion. As Congress considers proposals to reduce federal spending, doesn't it make sense to first look at federal subsidies for upper-middle class households?

12. One objection to the above proposal is that American above 300% of federal poverty will receive no subsidies, but still be forced to pay for ACA's expensive benefit mandates – leaving them without affordable coverage options. To address this issue, would it also make sense to allow any American to buy a catastrophic plan and reduce other ACA benefit mandates to promote affordability?

13. Physicians face a 21 percent cut in Medicare payments this April as a result of the Sustainable Growth Rate (SGR). A one-year "doc fix" to avoid this cut would cost about $15 billion, and a permanent fix, depending on the details, could cost anywhere from $120 to $180 billion. A lot has

been made about the need to "pay for" this fix. Isn't this just a budgetary snafu? Why should we have to offset stopping cuts to doctors that we all know won't actually happen?

14. Medicare spending grew last fiscal year by only 2.7 percent – the fourth lowest growth rate in history – despite a 3.8 percent increase in the number of beneficiaries. In large part because of these recent trends, the Congressional Budget Office (CBO) has revised down its future health care cost projections significantly. The agency now projects Medicare spending between 2012 and 2021 to be more than $500 billion lower than projections they made in March of 2011. In light of this good news, why should Congress be concerned about a *increase* in health care costs, and Medicare spending in particular?

15. Under the PREP plan you mention in your testimony, you would advocate for increased co-pays and changes to out of pocket limitations for some Medicare beneficiaries. How can you make these types of changes while still protecting those who are most in need?

16. Although our annual deficits have declined by about two-thirds since 2009, you argue that the long term debt will exceed the size of the economy sometime in the 2030s and will double the size of the economy between 2045 and 2080 as health and retirement spending continue to grow and revenues fail keep up. What is the practical impact of that level of debt on the American people? Is this something the average American really needs to worry about?

17. Seniors across the country rely on Medicare to meet their basic health care needs. What should we tell those folks back home that are worried about the need to make changes to the program. Should they be worried or concerned?

18. There was a lot of discussion on the first panel of the hearing regarding Medicare benefit modernization reforms. Can you discuss how cost-sharing reform can benefit both beneficiaries and Medicare?